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As a corollary of that point, where no emergency exists surgeons should be cautious and conservative when they think much different or much more extensive surgery is necessary than even their reasonable explanation had made provision for.

To come back to the original thought of the previous article, a person's person is his own; he, not the doctor, has the right to decide what treatment he will have. Permission to administer it must be obtained and that permission must be preceded by an explanation. Only then, if later the patient regrets the action, can the doctor hope to be safe legally.

CORRESPONDENCE

THE FAMILY PHYSICIAN

To the Editor:

In Dr. W. H. leRiche's article in the *Canadian Medical Association Journal* of October 1, 1955 (73: 572), he makes certain interesting statements. Some of these can be accepted as facts because they are documented by sound references; others more sweeping in character are supported neither by reference nor proof.

No one will dispute the need for good family physicians, but one would question his statement that "most specialists work only during office hours". This is obviously not applicable to obstetricians and in general has not been my experience with other specialists, in particular the internist, surgeon or pædiatrician.

More particularly one must challenge his view that "in general many specialists have regular hours and good incomes. Some have very high incomes. Physicians would like to enjoy these advantages and therefore become specialists". He implies that regularity of hours of work and improved economic return are the principal reasons which induce men to undertake specialization. In doing so he does a gross injustice to the majority of specialists whose motivation was to improve their service to the community by prolonged training and restriction of practice to fields where they were well informed and trained to provide better service in the field of their specialty. If one considers the loss of income inherent in the prolonged training which is now required for specialization and the time elapsing after qualification before one becomes established, it is doubtful whether the average specialist does as well financially as the general practitioner. Could Dr. leRiche enlighten us with some facts to support his conclusions in this respect? I would respectfully suggest that there are very few specialists at their peak who command better incomes than good general practioners of the same age group or who enjoy them for so long a time.

One cannot, as has already been stated, disagree with his statement that "the people need good general practitioners. The medical schools should produce such practitioners". This is the primary function of medical education. I am puzzled, however, by his further comment that "if the universities are not doing so at present, their orientation should be changed so that they can do this essential job". Does he imply that in the actual practice of medicine there is a fundamental difference in the management of medical, surgical and obstetrical problems which supports the view that they will be better treated by the family doctor than the specialist? In teaching obstetrics and gynæcology our efforts are directed toward general practice in these fields. We feel that the principles of management are the same whether practised by the family physician or specialist. Can or should we attempt to differentiate in our teaching efforts in this and other important branches of medicine, and specifically in what way would Dr. leRiche suggest this change should be directed?

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January 23, 1956.

To the Editor:

May I reply to Professor D. E. Cannell's welcome comments on my article "The Family Physician: A Vanishing Canadian?" (*Canad. M. A. J.*, 73: 572, 1955). The object of the article was to stimulate discussion, and it is heartening to see that in this aim it has been successful.

The first point to settle is the definition of a specialist. If a man limits his practice and has had certain specified postgraduate training and is certificated, then he is a specialist. But if he has a specialist certificate and does not limit his practice, then he is a general practitioner with a special interest. This might be quibbling, but we must be clear on terminology. In Ontario there are a substantial number of practitioners with specialist certificates, who are doing some general work. Such physicians have a sound influence on improving general technical standards of practice.

Obviously, the obstetrician has irregular hours, but the internist and surgeon can, to a reasonable extent, arrange their work as they wish, depending on whether they do consultant work mainly, or whether they do a greater proportion of general practice. Pædiatricians limit their work to an age-group, so that their hours would, in many instances, be similar to that of the general physician.

Why physicians specialize would be a question to which there could be a number of replies, Many people, as Dr. Cannell states, specialize because they want to do a better job. In others, the motivation would be different or somewhat mixed, as in most human affairs.

As to incomes by specialty, the following figures are from the United States, as details for Canada are lacking.

MEAN NET INCOME OF PHYSICIANS IN THE UNITED STATES 1949* (INDEPENDENT PRACTICE)

Neurological surgery	$28,628
Pathology	22,284
Gynæcology	19,283
Orthopædic surgery	18,809
Radiology	18,540
General surgery	17,765
Obstetrics and gynæcology	17,102
Neurology and psychiatry	16,476
Cardiology	15,589
Pædiatrics	12,016
General practice	8,835

*Weinfeld, W.: Income of Physicians, 1929-1949; *in* Survey of Current Business, U.S. Department of Commerce, Washington, D.C., 1951.

During recent years in the United States and most probably also in Canada the incomes of general practitioners and certain specialists have come closer together, so that there is often not so great a difference between incomes of general practitioners, pædiatricians and internists.

At a conservative estimate, the cost of medical training plus loss of potential income, while studying, comes to at least $25,000 up to the level of the M.D. and one year's internship. During training for a specialty, there would be a loss of potential income of at least $15,000. The specialist starting practice would be in the red to the extent of about $40,000, and he would be about five years older than his colleague who went immediately into general practice. From the American figures, one could estimate how long it would take the specialist to recoup his investment.

In Edinburgh, the Department of Preventive Medicine of the University runs a complete general practice, under the National Health Service, and in this practice students not only learn about the disease and social tensions most commonly found in communities, but they learn to know families in terms of their total environment.

In the new Medical School in Durban, the major clinical departments are Medicine, Surgery, Obstetrics and Gynæcology, and Family Practice, the latter including clinical preventive medicine and pædiatrics.

ONTARIO HOSPITAL POPULATION, 1951

Rank order	*Condition or disease*	*Percentage of total cases*
1	Confinements	16.6
2	Newborn care	16.1
3	Respiratory disease	14.0
4	Circulatory disease	4.7
5	All neoplasms	4.5
6	Appendicitis	3.8
7	Fractures	3.6
8	Disease of intestine, gallbladder, liver, peritoneum and pancreas	3.5
9	Disease of female genital organs	2.7
10	Disease of skin	1.8

ILLNESS IN THE CIVIL SERVICE, CANADA, 1952 - 1953

Condition or disease	*Percentage of total cases*
Influenza	22.4
Accidents, poisoning, violence	5.9
All other respiratory diseases	5.7
Bronchitis	4.7
Acute pharyngitis, hypertrophy of tonsils and adenoids	4.3
Symptoms and ill-defined conditions	4.2
Disease of stomach and duodenum	4.0
Acute nasopharyngitis	4.0
Arthritis and rheumatism	3.9
Diarrhœa and enteritis	3.8

It is good to hear reaffirmation that the primary function of medical education is to produce good general practitioners. This being the case, it would indicate a need for at least a few general practitioners to be on the clinical teaching staff of medical schools.

There is no fundamental difference in the technical management of medical, surgical and obstetrical problems, whether carried out by a specialist or general practitioner, but there is a difference in emphasis and orientation.

Perhaps we need a small illustration here in terms of a true story. A wealthy family came to live near a large city. The wife was pregnant and she went to a good obstetrician. She had a normal labour and the baby was fine. One week after returning home, she developed a uterine hæmorrhage and returned to hospital for a few days. The baby stayed at home. The father spent those hospital days transporting the mother's milk to the infant in a small freezer. This annoyed the infant, who did not like cold milk, and he experienced a series of digestive disturbances, which were solved in due course by a pædiatrician. When the mother returned home, she developed a mastitis, which was successfully treated by another doctor. Presumably, if this had progressed towards an abscess, she would have had to see yet another physician, a surgeon.

This family spent a large sum of money. Technically, each physician had done his best, but as medical care for a family it was most unsatisfactory. If only one of the physicians concerned had been interested in the whole family, the birth of a son and heir could have been the happy experience it should have been, instead of a state of near chaos at high cost.

In the list given above are shown disease and conditions in hospitals in Ontario and in the Canadian Civil Service. The differences in incidence are clear. The question arises whether medical students are not getting too much of hospital diseases, and then having to deal with a different set of conditions in general practice. This remark does not apply to obstetrics, as 96% of infants are born in hospital in Ontario, so that hospital experience is general experience in this field. Whether hospital practice meets the common minor gynæcological conditions should be investigated.

These are somewhat different approaches to the same problem, which is the training of good general practitioners.

Perhaps more issues have been raised in this letter than have been settled, but the discussion has been pleasant and stimulating, and quite possibly we could continue, subject to editorial approval.

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January 31, 1956.

DR. MAX RATNER: IN MEMORIAM

[The following tribute to the late Dr. Max Ratner, the Montreal surgeon who died in December, has been sent in by a patient and is printed as an example of a feeling towards physicians which, though undoubtedly very common, is seldom expressed in print.]

To the Editor:

The recent and sudden death of the well-known urologist and surgeon, Dr. Max Ratner, has saddened me terribly. To me this unforgettable doctor was exactly the type of person of whom a prominent Vienna professor of medicine of the last century made the well-known dictum: "Nur ein guter Mensch kann ein guter Arzt sein" (only a good man can be a good doctor).

I feel as if I had lost one of my own blood relations, for the following reason:

A few years ago I had developed trouble in the prostate, for which I was examined as an outpatient in local hospitals, with a recommendation for early operation. Unfortunately, at the end of a year I was still unable to get a public ward bed and was becoming desperate with pain and the fear of cancer, which is in my family. Through a local druggist friend, who had had a similar complaint treated by Dr. Ratner, I was given an introduction to Dr. Ratner, who told my friend to send me to his private office the next afternoon.